Business Council of Australia

Health Roundtable - Discussion Starter

OCTOBER 2015

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INTRODUCTION

The Business Council is a forum for the chief executives of Australia's largest companies to promote economic and social progress in the national interest. Our vision is to help make Australia the best place in the world in which to live, learn, work and do business.

Australia faces looming fiscal pressures, and this challenge needs to be addressed through program redesign. We believe health is the most critical program to address because it accounts for 15 per cent of total Commonwealth direct spending, and 25 per cent of total state spending. It is also vital to a productive economy and high living standards.

Redesign is about delivering better services, better outcomes, and more efficient delivery. With so much at stake, the Business Council is determined to re-establish a dynamic, informed, national debate which re-engages with the challenge of reshaping the healthcare system for a sustainable future, while maintaining or improving outcomes.

We think the starting point is to reposition the conversation, with a clear focus on problem identification, cost drivers, incentive design and information transparency. To build momentum, the Business Council and member company Australian Unity will co-host two roundtables in October and November 2015. The roundtables will convene policy experts with business leaders to look afresh at the challenge before us.

This discussion starter does not seek to prescribe specific measures to improve Australia's health system. Instead, it seeks to provide an organising framework for the roundtable discussions. It does this by outlining key statistics on the performance of Australia's health system relative to other industrialised nations and the key megatrends confronting the health system.

This data provides a foundation upon which we can build an agreed problem definition, identify areas requiring change, and prioritise reform.

This paper should be read in conjunction with the attached paper on megatrends prepared with the assistance of McKinsey & Company on specific trends and their implications, and the Technical Supplement.

This paper compares the health of the Australian population and the performance of the health system with that of seven other industrialised nations – Canada, Germany, Japan, New Zealand, the Netherlands, the UK, and the USA. These were chosen because they have similar standards of living and socioeconomic structures to Australia, but unique health systems.

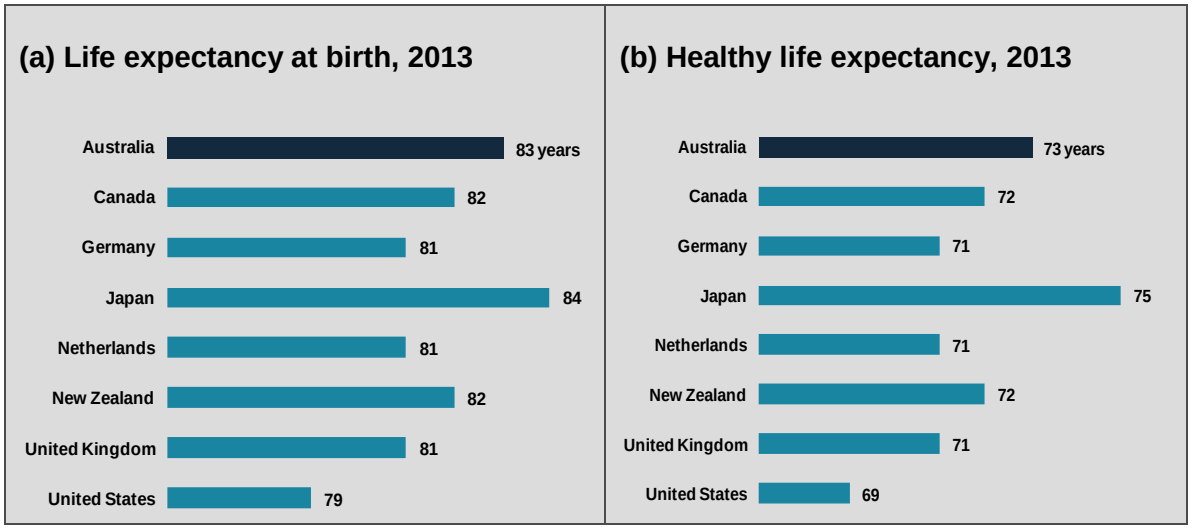
EXECUTIVE SUMMARY

Australia's health system performs well by international standards

Australians are healthy on most international measures, and our health care system performs well by international standards.

Australians are living longer than they ever have, and rank second of seven comparable populations on life expectancy and health-adjusted life expectancy. We also have among the best outcomes across a range of other indicators such as cancer survival rates and heart disease mortality.

Figure 1: Life Expectancy



Source: World Health Organisation, *World Health Statistics 2015*

While nationwide data can disguise poorer health outcomes of particular groups, such as the Indigenous community and other disadvantaged groups. Australia's health profile, and our health system, is one to be proud of by world standards.

Although we compare well, our system is under pressure

Nevertheless, there are issues and challenges within our health care system – in addition to the poorer health outcomes of specific groups – which must be addressed. The health of Australians and the outcomes our system delivers means we are starting from a good base, but the urgency to address these challenges is increasing.

Australia has experienced an extraordinary period of economic growth over the past quarter of a century and, as the economy has grown, governments and individuals have spent more of their income providing and accessing better health treatments.

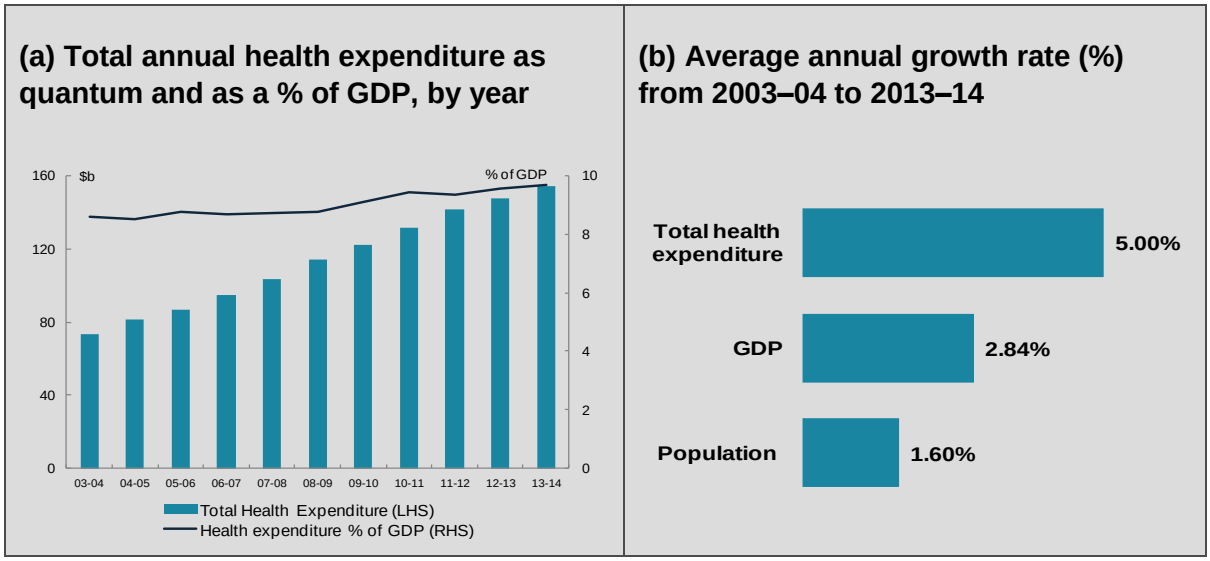
Essentially, many Australians are seeing doctors more often, having more tests, treatments and operations, and taking more prescription drugs than ever before.

Demand has also increased for new technologies, which offer huge positive health outcomes but are often expensive.

An ageing population, which is increasingly demanding the best health care available, is accelerating these trends.

As a result, over the past decade we have had a five per cent average annual real growth in health expenditure – faster than annual GDP growth over that period of three per cent.

Figure 2: Health Expenditure



Source: Australian Institute of Health and Welfare, *Health Expenditure 2013–14*

Change is needed to slow the growth in health expenditure

The system which has served Australia well for many decades is built on an incentive structure which can create adverse costs and perverse behaviours. Australia's funding model is primarily a fee-for-service one, and fee-for-service can incentivise volume of care.

There are also clearly issues to do with where care is delivered, system efficiency, over-diagnosis and over-treatment, and waste.

For example, we have high levels of potentially preventable hospital admissions relative to comparable countries. Spending on all components of the health system has been growing faster than GDP, and spending on hospitals – which is the largest cost – has been growing the second fastest of the key service components.

The Productivity Commission (PC) has found efficiency of the health sector could be increased by up to 20 per cent by bringing performance up to best practice across a range of areas. The PC found that a five per cent productivity improvement in health could reduce fiscal pressures by 0.5 per cent of GDP in 2060 or $8 billion in today's terms.

Rising health expenditure is also impacting individuals. The share of total health expenditure met by individuals via out-of-pocket expenses is growing. It now accounts for 20 per cent of overall costs, which ranks as the highest of all comparator countries.

Similarly, private health insurance premiums have increased by an annual average of 3.3 per cent in real terms since 2010 (while real disposable income rose by an annual average of 0.9 per cent over the five years to 2015). If these high increases continue, it is

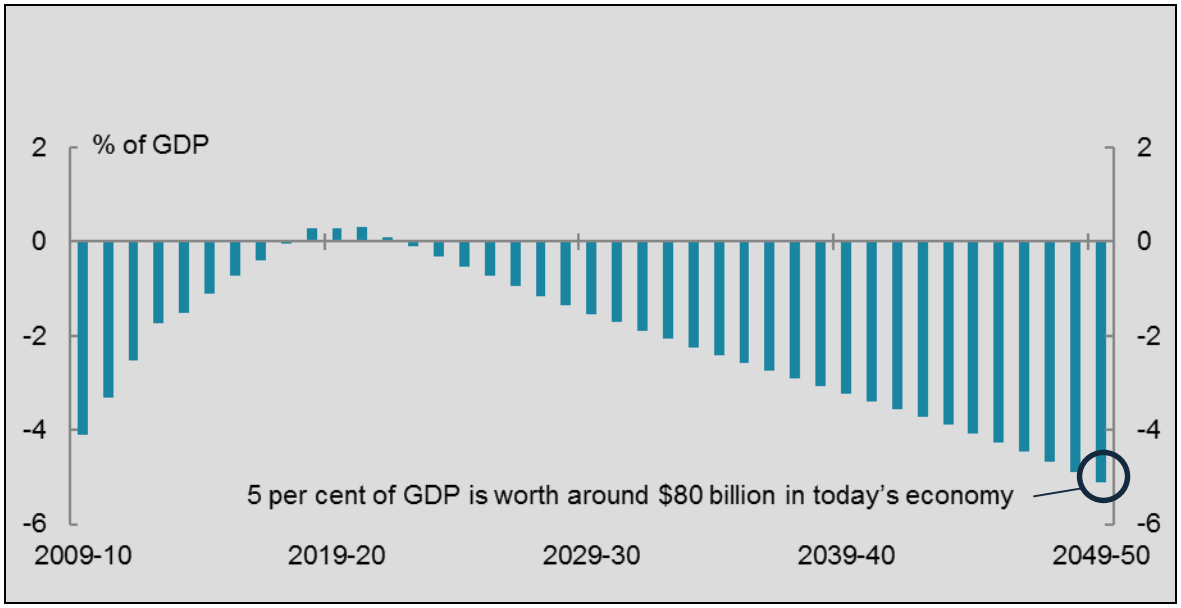
possible that private health insurance could be increasingly unaffordable for many Australians. This would threaten the viability of the industry, and place greater demands on the public health system.

Our reality demands a rethink and redesign

While rising health costs may have been acceptable to large parts of the community in past decades, particularly given generally good health outcomes and health care performance, the fiscal pressures are now significant.

With no policy change, and if government spending continues to grow at the current rates, it is estimated that the combined annual fiscal deficit across all levels of government could reach five per cent of GDP by 2050, or around $80 billion in today's economy. Health spending is a significant part of this fiscal gap.

Figure 3: Project fiscal balance of all governments



Source: Deloitte Access Economics, 'An Intergenerational Report for the States', incorporated within the BCA submission to the 2011 Tax Forum, October 2011

NSW Premier Mike Baird predicted annual deficits for combined governments by 2030 of $45 billion, of which approximately $35 billion would be generated by health.[1]

The choice is clear. If we wish to affordably maintain or improve our health outcomes and services in the years ahead, we must move deliberately to redesign health spending programs to reduce waste and inefficiency and ensure our system is delivering better quality and value for our health dollar.

Success in redesigning the health care system to be sustainable for the long term will be fundamental to putting the budgets of all governments back on track.

[1] M Baird: 'Raise the GST to 15 per cent to Pay for Healthcare', *The Australian*, accessed 25 September, 2015, http://www.theaustralian.com.au/opinion/mike-baird-raise-the-gst-to-15-per-cent-to-pay-for-healthcare/story-e6frg6zo-1227448117813.

Reform of health has long been on the agenda of governments, and reform of health should always been on the agenda. Health reform needs to be a continuous improvement process. We need to move away from the stop-start nature of recent health reform debates, and ensure we are starting from the right premise.

Our health system consists of a patchwork of practices and system design attempts from past decades when our health profile and available technology were different. The latter two have changed, but our health system has not kept pace with these changes. Consumers are also very different. Other sectors have gone through significant change, driven by consumers demanding automation, connectivity, and information.

We must seize and deploy within our health systems the extraordinary learnings from the last three decades of industrial systems' improvement. As the attached paper on megatrends demonstrates, emerging trends present further opportunities for change, as well as challenges.

Ahead of us is a great opportunity to improve health care delivery, quality and efficiency. By doing so, we can maintain our safety net, our high-quality system and our comparative advantage, and re-target funding to new and exciting technologies and products surfacing by the day.

At its heart, redesigning health programs will require genuine conversations about identifying waste, low value care, and coordination problems within the existing system, as well as grasping the vast opportunities inherent in the emerging megatrends.

By tackling this challenge with optimism and collaboration, Australia can remain the envy of the world for a health system that is not only one of the world's best, but is future-facing and sustainable for the whole community.

PART 1: AUSTRALIANS HAVE GOOD HEALTH BUT WE HAVE GAPS IN OUR SYSTEM'S PERFORMANCE

Australia's health compares well

Australians are living longer than they ever have

Health is vital for quality of life. It influences how we feel and function, and contributes to individual wellbeing and happiness. It is also an important precondition for effective participation in society, education and the economy, which will underpin greater national productivity.

An individual's health is shaped by many factors including genetics, access to effective health services, income levels, environmental factors, lifestyle, and individual choices.

Most Australians live long and healthy lives. Against seven comparable nations, Australia ranks second behind Japan for life expectancy at birth, and for health-adjusted life expectancy.

Despite these nationwide outcomes, several sub-groups in Australia record poorer health outcomes than the broader population.

Life expectancy for Indigenous Australians is around 10 years shorter than for non-Indigenous Australians. Australians living in regional and remote locations also tend to have poorer health outcomes than those living in major cities. People from lower socioeconomic groups also tend to have poorer health.

Living with disease is increasingly common in Australia and globally

The extraordinary advances in medical science means there is now early diagnosis for diseases, prevention of premature death, and prolonging life. People's lives are prolonged such that they have the opportunity to spend time with their families, continue to work, and contribute to society. The natural corollary of this is that these people are now living with disease for a longer part of their lives.

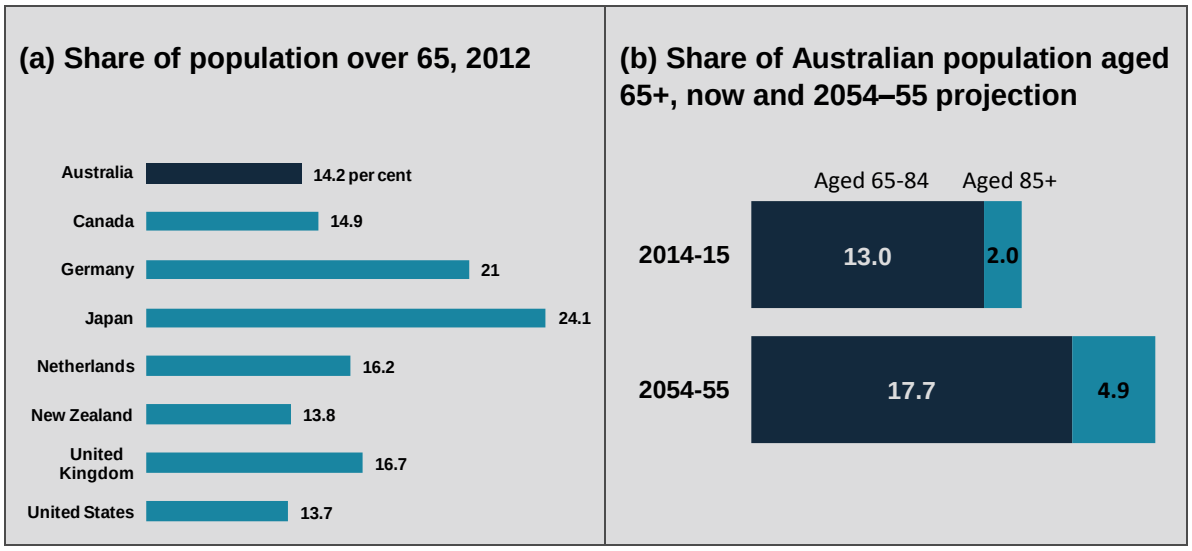
Australia is now witnessing increased rates of chronic and age-related conditions. For example, the rate of self-reported diabetes more than doubled (from 1.5 per cent to 4.2 per cent) between 1989–90 and 2011–12. The number of dementia sufferers is projected to reach 900,000 by 2050.[2]

Australia's ageing population will demand more of the health system

Like all first world countries, Australia is facing the challenge of an ageing population. In 20 years, 2445 more Australians will be turning 75 each week than currently. The number of Australians aged 65 and over is projected to double by 2055.

[2] Australian Institute of Health and Welfare, "Dementia in Australia" (Canberra, 2012).

Figure 4: Australia's ageing population



Source: The Commonwealth Fund, *International Profiles of Health Care Systems 2014*, Commonwealth Treasury, *Intergenerational Report 2015*

An ageing population typically leads to higher health expenditure because older people use the system more. An increased availability and use of health treatments will further exacerbate this growth in costs as the population ages.

The Australian health system has a mixed record of performance

A health system's performance can be usefully assessed across eight key dimensions. Australia has good health outcomes overall, but receives mixed ratings across the various dimensions.

The following section discusses these key dimensions and uses a 'traffic light' system to identify the areas where reform could take place.

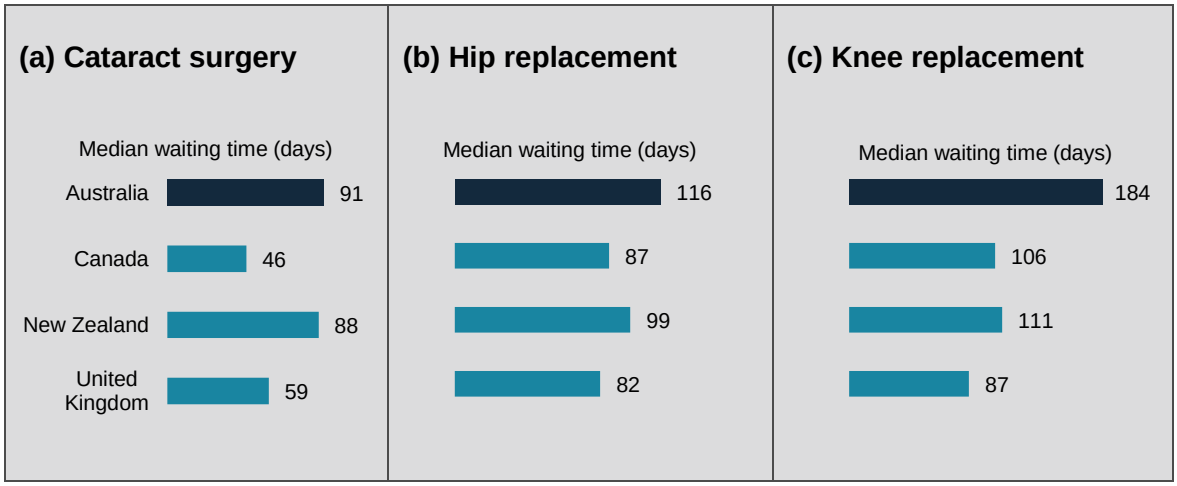
Green text indicates Australia performs well in the dimension, orange text indicates improvement could take place, and red text indicates there is a need for a strong improvement focus.

Access to health care

Definition	Performance
Access to health care covers availability of services, geographic proximity of services, waiting times, and the level of out-of-pocket payments required.	• **Through Medicare, Australians have free or subsidised access to a core package of health goods and services. These services cover the majority of needs of Australians, but there are a range of health services excluded such as ambulance services, glasses and contact lenses, and most dental examinations.** • **While Australia performs well on overall access, its performance for elective surgery is not as impressive. As detailed in the charts below, Australia ranks last of the four comparable nations on median waiting times for three common types of elective surgery - cataract surgery, hip replacement and knee replacement.**

Definition	Performance
	• Out of pocket expenses is also a key indicator of access, and Australia has the highest rate of out-of-pocket expenses as a share of household spending (3.2%) of the seven comparator countries for which data is available.[3]

Figure 5: Waiting times for selected procedures



Source: OECD, *Health at a Glance 2013*

Appropriateness/waste

Definition	Performance

Appropriate health care relies on balancing the benefits, risks and costs of treatment options with the preferences of an informed patient. Inappropriate care includes unnecessary tests, over-diagnosis, overtreatment, and non-evidence based care. These can expose the patient to risks and unnecessary costs.	• A range of studies suggest appropriateness/waste is a key area where improvements could take place:
	  • A 2015 Grattan Institute report found that nearly 6000 people – or 16 people a day – received one of five treatments in 2010–11 despite evidence that it was unnecessary or would not work in their individual circumstances.[4]
	  • Recent research has identified more than 150 low or no value health care practices in Australia that deliver marginal benefit.[5]
	  • The Productivity Commission observed in April 2015 that governments and patients spend a considerable amount of money on health interventions that are irrelevant, duplicative or excessive, provide very low or no benefits, or, in some cases, cause harm.[6]
	  • Figure 6 shows that Australia has high rates of admissions for both Chronic Obstructive Pulmonary Disease (COPD) and diabetes. A high-performing primary care system can, to a significant extent, prevent such admissions to hospital.[7]

[3] OECD, *Health at a Glance 2013: OECD Indicators*, 2013.

[4] S Duckett, P Breadon, D Romanes, P Fennessy, J Nolan, *Questionable Care: Stopping Ineffective Treatments,* Grattan Institute, 2015.

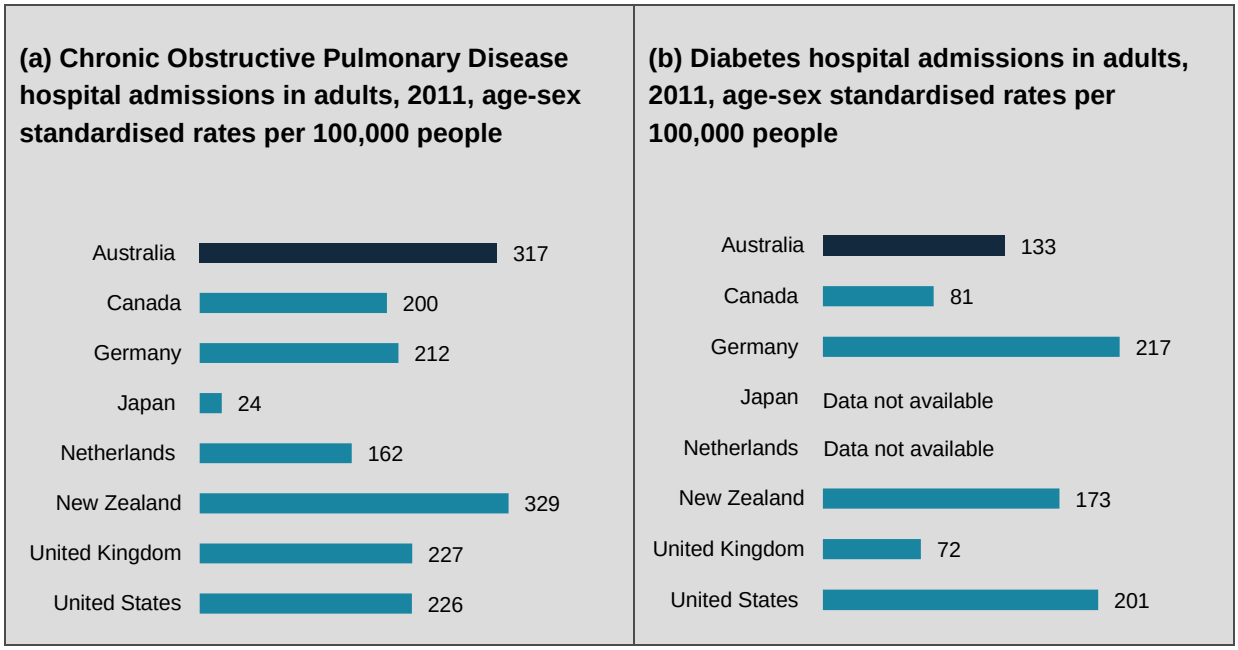
[5] AG Elshaug et al., 'Over 150 Potentially Low-Value Health Care Practices: An Australian Study', *Medical Journal of Australia* 197, no. 10, 2012, https://www.mja.com.au/journal/2012/197/10/over-150-potentially-low-value-health-care-practices-australian-study.

[6] Productivity Commission, *Efficiency in Health, Productivity Commission Research Paper*, 23 April 2015, http://www.pc.gov.au/research/completed/efficiency-health.

[7] OECD, *Health at a Glance 2013: OECD Indicators*.

Definition	Performance
	• In addition to exposing patients to risks, there is a financial cost involved in appropriateness/waste. For example, the Grattan Institute has found that over $1 billion per year is spent on potentially avoidable hospital admissions for chronic disease.

Figure 6: Hospital admissions for selected conditions



Source: OECD, *Health at a Glance 2013*

Coordinated care

Definition	Performance
Coordinated care is where services and treatments are linked, and patients can easily move between primary, secondary and hospital services.	• While patients can move between different modes of care, many complain of information gaps, fragmented services and duplication of interventions.[8] • Like many countries, Australia is currently implementing an electronic health record. This will allow the individual and clinicians at any location to access a detailed, up-to-date patient history and should dramatically improve coordinated care. • However, only a small minority of consumers are early adopters. This differs from other industries where technology has been introduced to support self-management, and points to the opportunities the health sector has yet to grasp. • Uncoordinated care most affects frequent users of the health system, especially patients with chronic illness. Much of the fragmentation results from the web of government and non-government-funded services, and is at times exacerbated by the split of government responsibilities.

[8] J Horvath, *Review of Medicare Locals: Report to the Minister for Health and Minister for Sport*, Report to the Commonwealth Government, 2014.

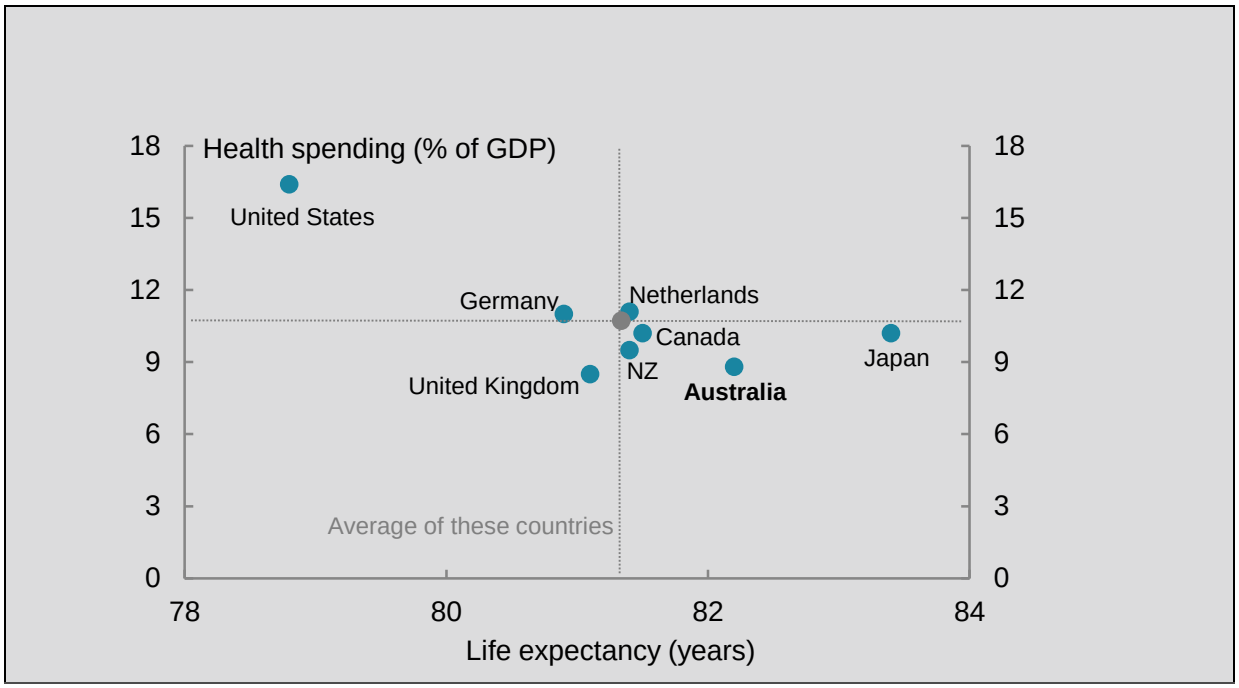
Effectiveness

Definition	Performance
The effectiveness of health care is the degree to which health care practices, techniques and pharmaceuticals produce, as far as possible, a clinically desired outcome.	• For life threatening illnesses, Australia performs well on urgent care. It has the highest 5-year relative survival rate for breast cancer, and the second lowest case-fatality rate for heart attacks. • For chronic disease, the performance is not as positive. As previously noted, Australia has high rates of potentially avoidable hospital admissions for chronic diseases such as Chronic Obstructive Pulmonary Disease and diabetes. This suggests ineffective care in the community.

Efficiency

Definition	Performance
Efficiency in health care is the degree to which a set of inputs (i.e. funding) can be used to produce outcomes (e.g. an additional year of life).	• Figure 7 shows that Australians enjoy a high life expectancy (an outcome) and utilise a modest expenditure (input) relative to other OECD countries.

Figure 7: Life expectancy relative to health spending (as a % of GDP), 2013



Source: OECD, http://stats.oecd.org/, accessed 20 October 2015; 2013 data for all countries, except 2011 for Canadian life expectancy and 2012 for Australian health spending as a percentage of GDP. The data differs from that mentioned earlier in this discussion paper because OECD and AIHW use different methodologies for expenditure calculations, and OECD life expectancies relate to 2013.

Efficiency (continued)

Definition	Performance
Efficiency in health care is the degree to which a set of inputs (i.e. funding) can be used to produce outcomes (e.g. an additional year of life).	While Australia has a good life expectancy against expenditure, an assessment of efficiency cannot be limited to this measure. • **In 2006, the PC's assessment of existing studies suggested that the efficiency of the health sector could be increased by up to 20 per cent by bringing performance up to best practice across a range of areas.[9]** • **Subsequently, detailed analysis by the PC estimated that the efficiency gap between the average and most efficient acute-care hospitals was likely in the order of 10 per cent.[10] These variations consist of avoidable costs such as keeping people in hospital too long, or overpaying for supplies.**

Information availability

Definition	Performance
Informed decision making is based on the consumer (or patient) having access to sufficient information to make an informed decision about the good or service they are purchasing.	• **The Productivity Commission has found that the United Kingdom, the United States and Canada outperform Australia in collecting and releasing data on areas of health service delivery.[11]** • **Performance data is not currently reported for individual hospital clinicians, general practitioners nor other professionals in Australia. In contrast, the UK publishes outcomes data for surgery specialties, including volume of operations, readmission rates, complication rates and in-hospital survival rates. England also publishes GP performance.** • **Several US states have reported publicly on the performance of individual cardiac surgeons since the early 1990s. There is evidence that public reporting improves clinical outcomes.[12]** • **Cost information is also scarce in Australia's health system. The Medicare Benefits Schedule Review Taskforce has observed that consumers often find it difficult to obtain clear information about how much services cost, including the total cost, the Medicare benefit, the private health insurance contribution (where applicable) and the out-of-pocket costs.[13] This limits their ability to make informed decisions. In contrast, the US Government has recently started publishing payment data for GPs and specialists that receive Medicare funding.[14]**

Prevention

Definition	Performance
Preventative health allows people to remain as healthy as possible for as long as possible. It is commonly pursued through public health campaigns (e.g. to lower smoking rates) and effective primary care.	• **While Australia has had successful road death prevention campaigns, and has low rates of smoking, it ranks eighth for vaccination rates of children aged around one against diphtheria, tetanus and pertussis.**

[9] Productivity Commission, *Potential Benefits of the National Reform Agenda*, Report to the Council of Australian Governments, Canberra, 2006.

[10] Productivity Commission, *Public and Private Hospitals: Multivariate Analysis*, Supplement to Research Report, Canberra, 2010.

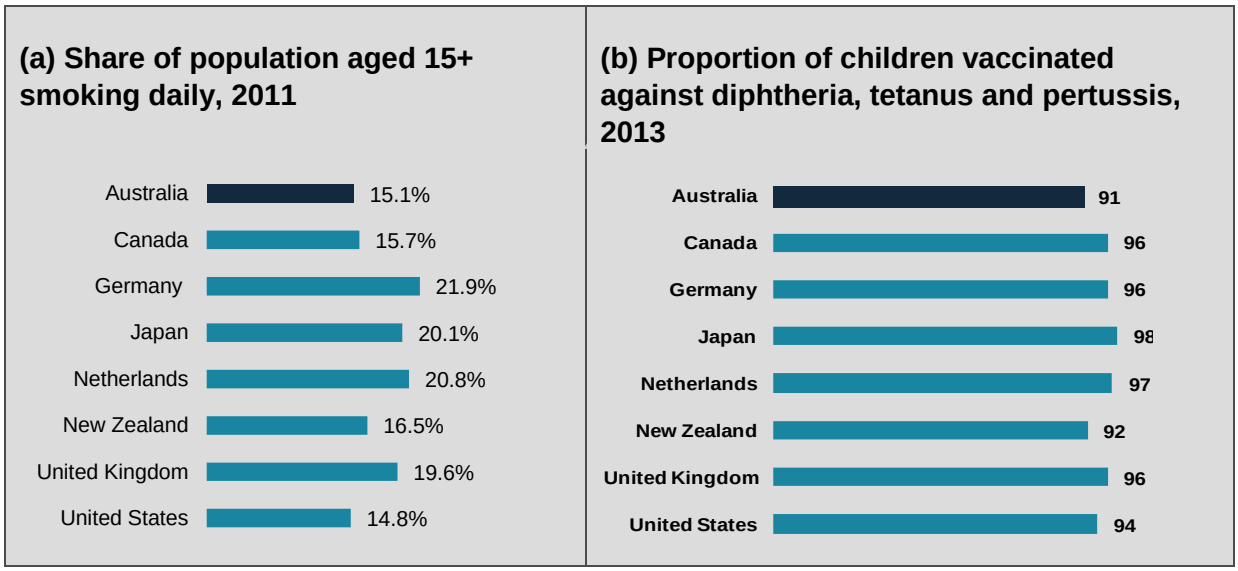
[11] Productivity Commission, *Efficiency in Health.*

[12] E Hannan, K Cozzens, S King, G Walford, N Shah, *The New York State Cardiac Registries*, Journal of the American College of Cardiology, Vol 59, No 25, 2012.

[13] Medicare Benefits Schedule Review Taskforce, *Medicare Benefits Schedule Review Taskforce – Consultation Paper*, September 2015.

[14] Productivity Commission, *Efficiency in Health.*

Figure 8: Rates of smoking and vaccination

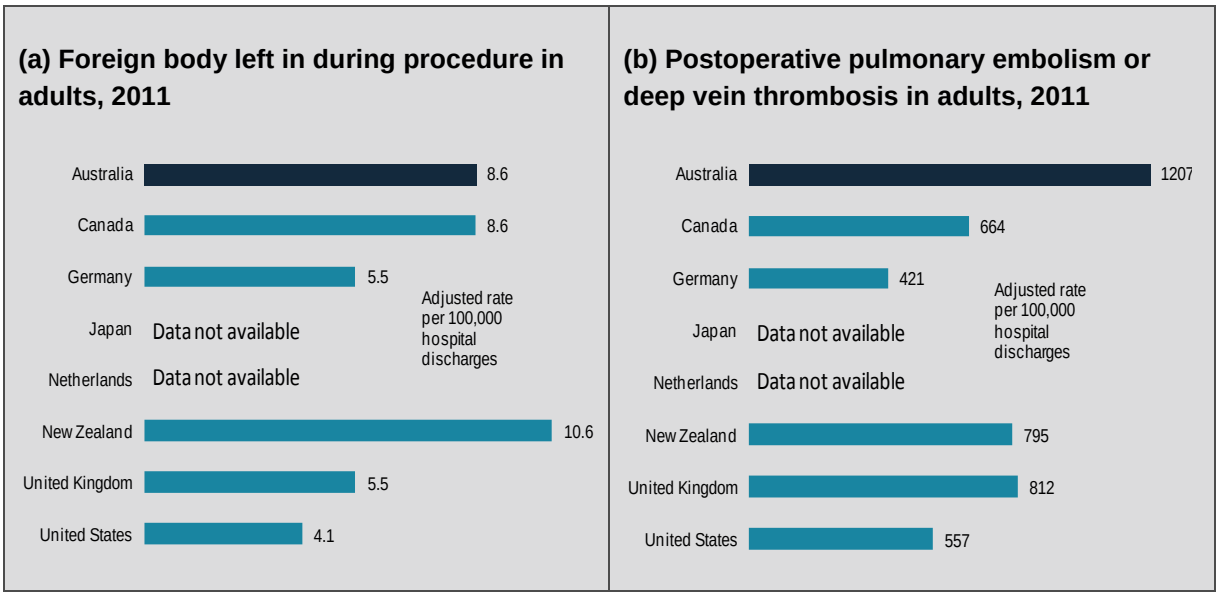


Source: OECD, *Health at a Glance 2013* & OECD Stat, http://www.stats.oecd.org.

Safety

Definition	Performance
Safety in health care is the degree to which potential risks and unintended results for patients and others are avoided or minimised.	• Two categories of events can harm a patient: sentinel events that should never occur (e.g. failure to remove surgical foreign bodies after a procedure) and adverse events (e.g. infections, falls) some of which can never be fully avoided. ○ Australia rates poorly on sentinel events and has the second highest rate of "foreign body left in during procedure". ○ There is no national system for counting adverse events. • The Australian Commission on Safety and Quality in Health Care estimates that preventable adverse events in Australia add between 6 and 10 per cent to costs of the system.

Figure 9: Selected rates of sentinel and adverse events



Source: OECD, *Health at a Glance 2013*

Our system's performance can and should be improved

The analysis of these key dimensions demonstrates that despite our overall health outcomes, there are some key areas where significant progress could be made, including appropriate care, waste, efficiency and access to information.

This progress would not focus on cutting costs or services. Rather, it would focus on harnessing the megatrends that are emerging. For example, Australia performs poorly on information availability. The technological innovations that have created paradigm shifts in other sectors could overcome this lack of information, and empower many Australians to self-manage their health.

PART 2: HEALTH SPENDING IS NOT SUSTAINABLE

Demand for health services continues to grow

Australia has experienced a sustained period of economic growth. As the economy has grown, governments and individuals have spent more of their income providing and accessing more and better health treatments, including new technologies. Additionally, Australians' expectations of available and convenient services – not limited to health – have grown.

The corollary is that many Australians are seeing doctors more often, having more tests, treatments and operations, and taking more prescription drugs than ever before.

For example:

- In 2013–14, an average of 15 services per capita attracted Medicare benefits (an increase from 11 services in 2003–4).[15]
- The age-standardised rate of hospital separations increased from 379 per 1000 population in 2009–10 to 395 per 1000 population in 2013–14.[16]
- The number of emergency occasions of service increased by an average of 2.6 per cent each year between 2009–10 and 2013–14.[17]
- The number of outpatient care occasions of service increased by an average of 2.5 per cent each year between 2009–10 and 2013–14.[18]

Many of these interventions deliver longer and healthier lives, but each has a cost.

Meeting service demand means greater expenditure

In 2013–14, total spending on health from all sources was estimated at $154.6 billion. This accounted for 9.78% of GDP.[19]

Figure 10(a) shows that total health expenditure has been increasing each year and also as a proportion of GDP. Figure 10(b) shows that health expenditure grew at five per cent per annum on average over the decade to 2013–14, which was significantly faster than GDP (2.84%) and population growth (1.6%).

[15] http://medicarestatistics.humanservices.gov.au/statistics/mbs_group.jsp

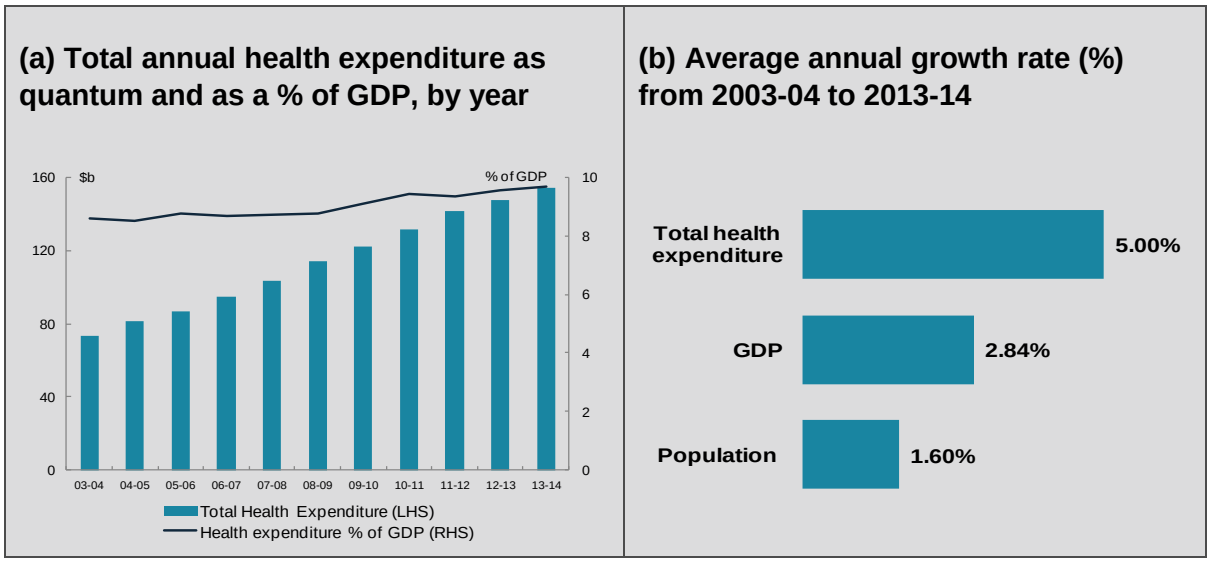
[16] Australian Institute of Health and Welfare, *Admitted Patient Care 2013–14: Australian Hospital Statistics*, Health Services Series No. 60, Cat. No. HSE 156, AIHW, Canberra, n.d.

[17] Australian Institute of Health and Welfare, *Non-Admitted Patient Care 2013–14: Australian Hospital Statistics*, Health Services Series No. 62. Cat. No. HSE 159, AIHW, Canberra, 2015.

[18] Ibid.

[19] Australian Institute of Health and Welfare, *Health Expenditure Australia 2013–14*, Cat. no. HWE 63, Health and Welfare Expenditure Series, Canberra, 2015.

Figure 10: Health Expenditure

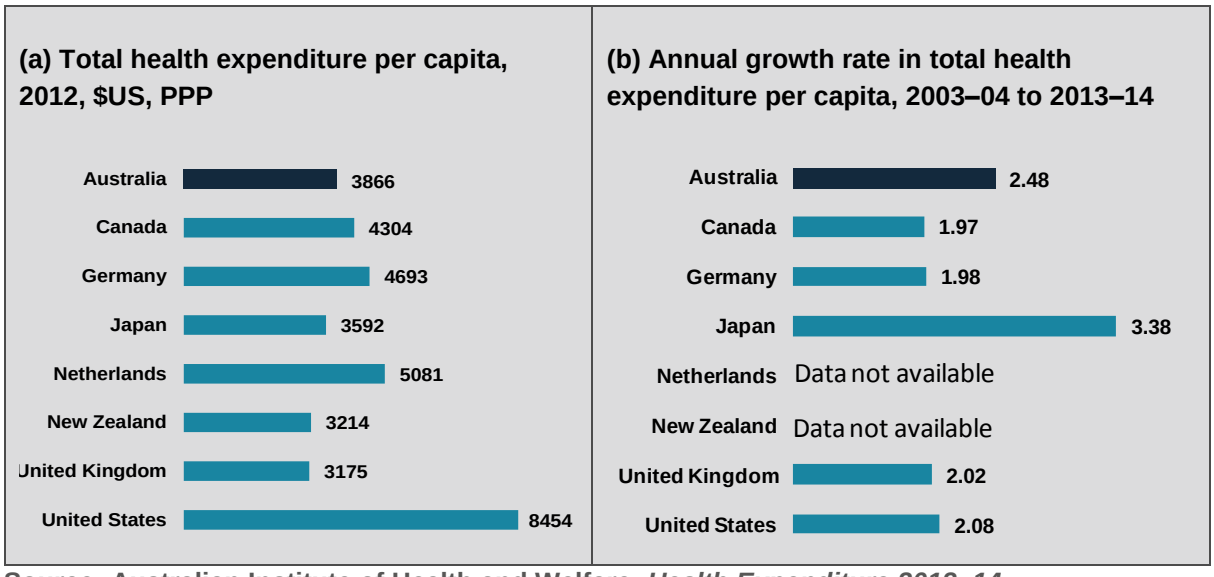


Source: Australian Institute of Health and Welfare, *Health Expenditure 2013–14*

Australia's estimated health expenditure per capita in 2013–14 was $6,639.[20] This is mid-range of the eight comparator countries – see Figure 11(a). It is higher than the UK, New Zealand and Japan, and lower than Canada, Germany, the Netherlands and the United States.

Australia's health expenditure per capita grew second fastest of comparable countries between 2003–04 and 2013–14, and approximately 0.5 per cent faster than the next four – Figure 11(b).

Figure 11: Health Expenditure per capita



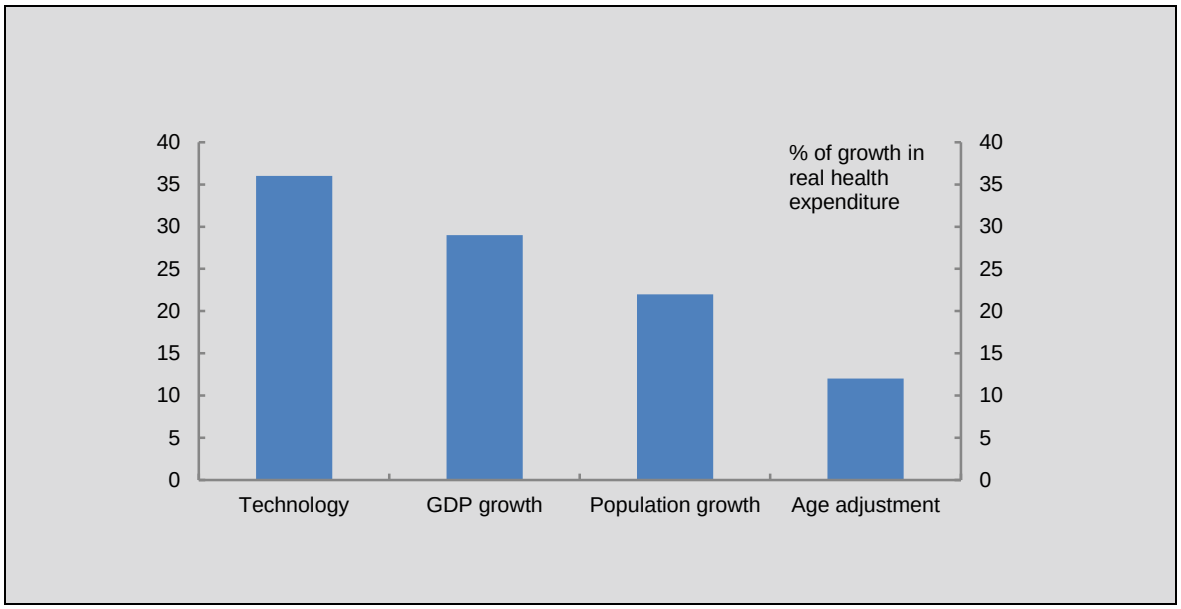
Source: Australian Institute of Health and Welfare, *Health Expenditure 2013–14*

A mix of factors drive growth in health expenditure, including population growth, population ageing, income growth and new technologies.

[20] ibid.

Figure 12 depicts the PC's estimates of the share of growth in real health expenditure from each of these drivers over the decade to 2002–03 (GDP growth is a proxy for income growth).

Figure 12: Impact of drivers of health spending, 1992–93 to 2002–03



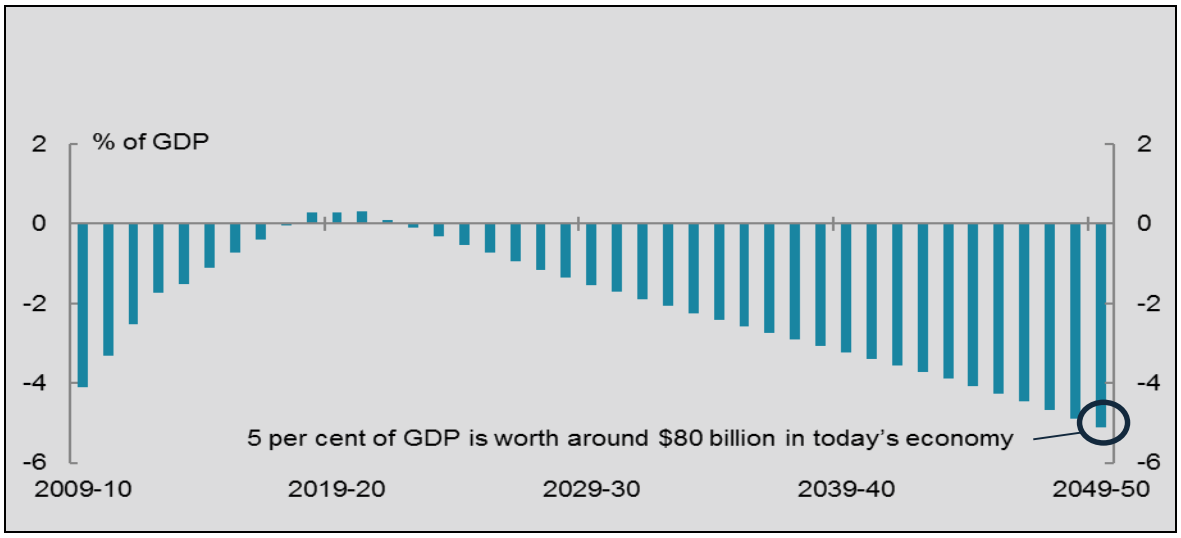
Source: Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, 2005

Significantly, the effects on health costs of some factors are not independent of each other. For example, the PC observes that new technologies and an ageing population interact with each other to compound costs. It notes that many technologies are developed for use by older Australians, who will comprise an increasing share of the consumer market as a consequence of demographic change.[21] The growth in government health expenditure is not sustainable.

With no policy change, and assuming demand continues at projected rates, it is estimated that the combined annual fiscal deficit across all levels of government could reach five per cent of GDP by 2050, or around $80 billion in today's terms.

[21] Productivity Commission, *An Ageing Australia: Preparing for the Future*, Canberra, 2013.

Figure 13: Projected fiscal balance of all governments

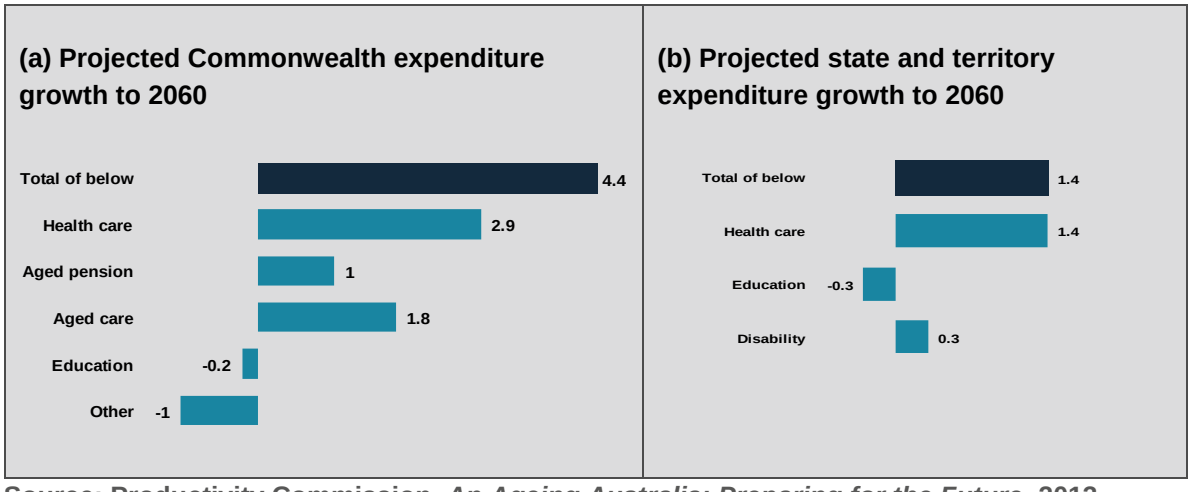


Source: Deloitte Access Economics, 'An Intergenerational Report for the States', incorporated within the BCA submission to the 2011 Tax Forum, October 2011.

Other estimates have been placed in the public domain. For example, in July 2015 the NSW Premier Mike Baird predicted annual deficits for combined governments by 2030 of $45 billion, of which approximately $35 billion would be generated by health.[22]

In 2013–14, governments provided $104.8 billion, or 67.8 per cent of total health expenditure.[23] Health spending has been a significant driver of spending growth across governments, rising from 17 per cent of combined government expenditure in 2002–03 to 19 per cent in 2012–13.[24] Figure 14 shows that health is predicted to be the largest driver of fiscal pressures.

Figure 14: Projected government expenditure



Source: Productivity Commission, *An Ageing Australia: Preparing for the Future*, 2013

[22] "Mike Baird."

[23] Australian Institute of Health and Welfare, *Health Expenditure Australia 2013–14*, Canberra.

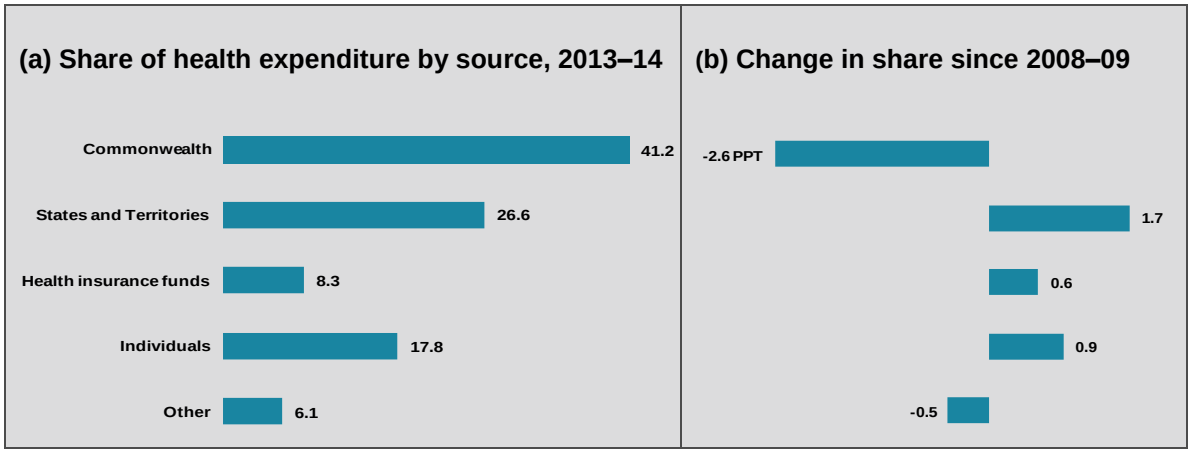
[24] Australian Government Parliamentary Budget Office, *National Fiscal Trends*, 2015.

As demand for health services continues to rise, accelerated by an ageing population, overwhelming pressure will be placed on governments' spending capacity. If government health expenditure continues to grow at the current rate it will overwhelm budgets, crowding out other spending priorities in areas such as education and infrastructure necessary to fuel future growth.

Expenditure growth has not been limited to governments

Figure 15 shows that the share from the Commonwealth Government and other non-government sources (e.g. payments by compulsory motor vehicle third-party and workers compensation insurers) has fallen since 2008–09. At the same time, the share contributed by state and territory governments, individuals (via out-of-pocket expenses), and private health insurers has risen.

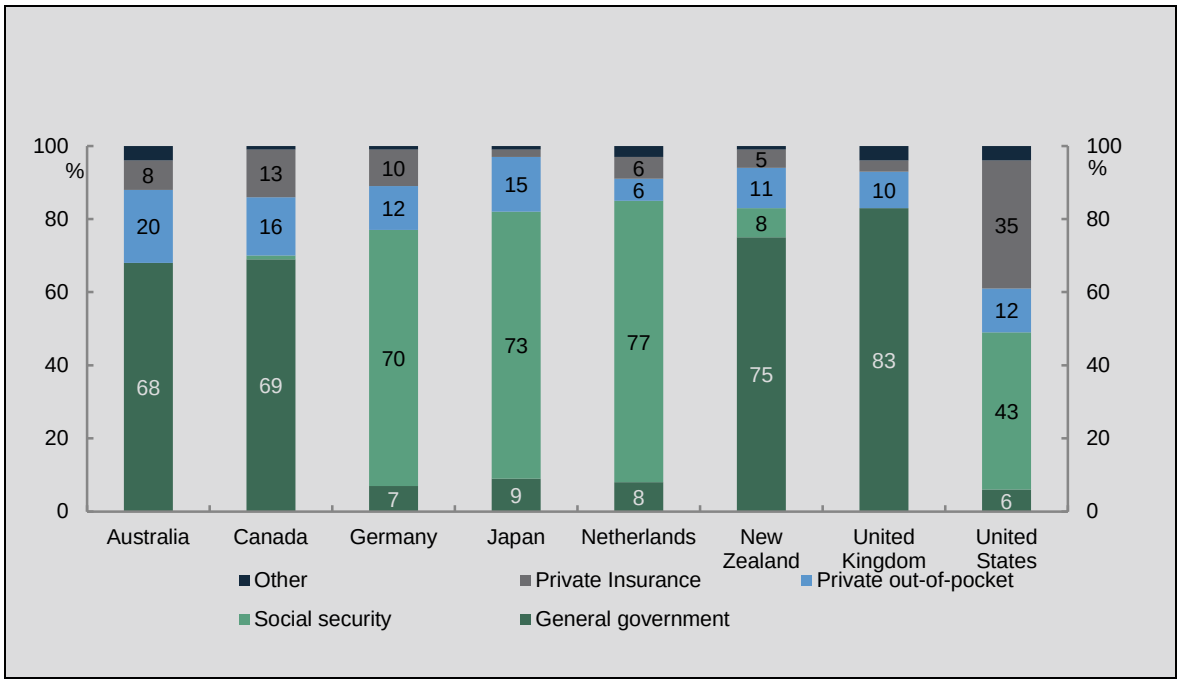
Figure 15: Sources of health expenditure



Source: Australian Institute of Health and Welfare, *Health Expenditure 2013-14*

Figure 16 shows that Australia's government expenditure on health ranks as the second lowest share of total health expenditure (68 per cent) ahead of the United States (49 per cent). It also shows that out-of-pocket expenses by individuals in Australia account for 20 per cent of overall costs, which ranks as the highest of all eight countries.

Figure 16: Proportion of total health expenditure by funding source, 2011



Source: OECD, *Health at a Glance 2013*

Individual financial contributions to health in Australia is substantial

The level of an individual's contribution to Australia's health system depends on their financial circumstances and their use of the system. The contributions can include:

- the Medicare Levy (paid by nine million Australians in 2012–13)
- the Medicare Levy Surcharge (paid by 200,000 Australians in 2012–13)
- co-payment for products or services where applicable (e.g. script co-payments)
- Private health insurance premiums (paid by 13.1 million Australians in 2014, the annual premium for basic hospital cover for a single is approximately $800)

Between 2003–04 and 2013–14, out-of-pocket expenses grew at an average annual growth rate of 6.2 per cent. This translates to individuals providing $27.5 billion via out-of-pocket expenses, or 17.8 per cent of total health expenditure in 2013–14.[25] It is typical for individuals to divert an increasing portion of their disposable income to health when real incomes are rising. However, similar to the situations governments face with growing health expenditure, this above-trend annual growth risks overwhelming household budgets.

[25] Australian Institute of Health and Welfare, *Health Expenditure Australia 2013–14*, Canberra.

Services demand also impacts private health insurance

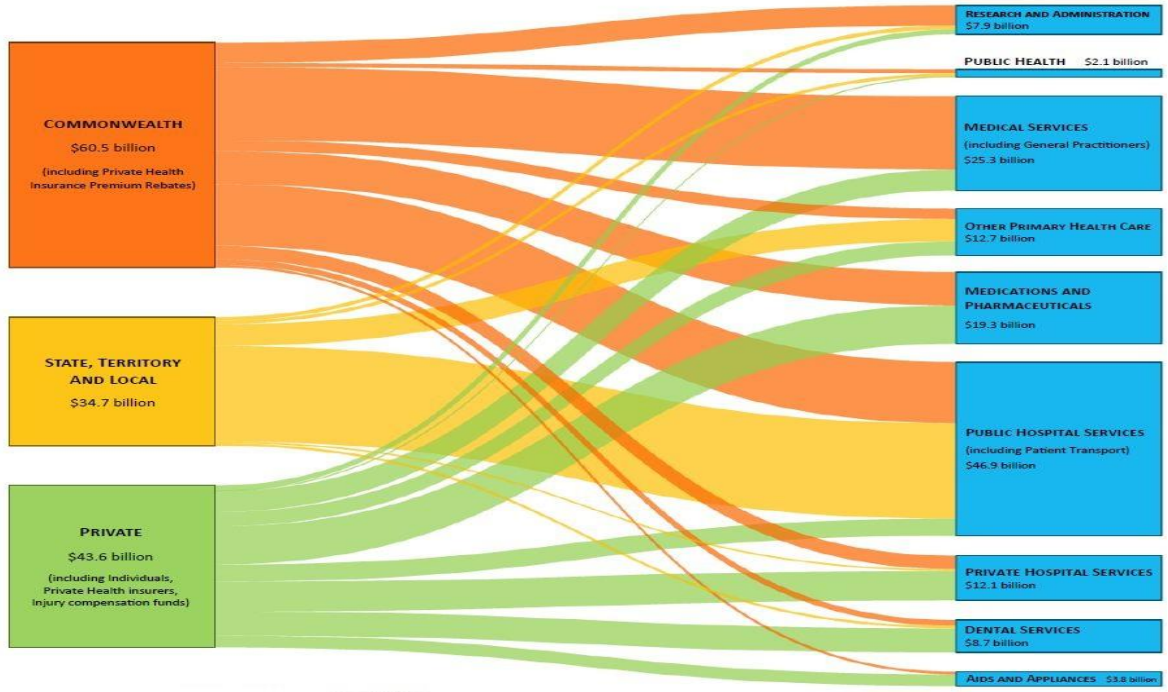
In 2013–14, private health insurance funds provided $12.9 billion, or 8.3 per cent of total health expenditure.[26] The average annual growth rate of private health insurance funding of total health expenditure from 2003–04 to 2013–14 was 5 per cent.[27]

More revealingly, premiums increased by an annual average of 3.3 per cent (in real terms) between 2010 and 2015.[28] If these high increases continue, it is possible that private health insurance will begin to become increasingly unaffordable for Australian households. If this were to occur, it would increase demand on the public health system, which would in turn increase demand on government expenditure, and therefore on taxpayers.

Incentives, not funding arrangements, are a key problem

As illustrated in the diagram below, health funding arrangements and funding flows can be complicated.

Figure 17: Health funding flows



Source: Commonwealth of Australia, 'Reform of the Federation White Paper, Issues Paper 3: Roles and Responsibilities in Health', 2014

Some commentators argue that these funding flows create unnecessary complexities, and that these complexities are the problem to solve. The funding flows are complex, but complexity is part of any system that caters for all Australians.

[26] ibid.

[27] ibid.

[28] Business Council of Australia analysis of Commonwealth Department of Health data at http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round

The funding flows do not demonstrate duplication between levels of government, nor explain the growth in expenditure. The funding flows, and allocation of responsibilities between levels of government, are not the problem to solve.

In addition to the cost drivers already discussed, the problem to solve is the incentives structure in the health system.

Incentive structures are critical to the funding model design

The Australian health system hosts a complex interplay of interests among a myriad of stakeholders. Incentive design is therefore complex, but vitally important.

Consumers, providers, private health insurance funds and governments all face a range of incentives and disincentives in the health system. These influence the choice of:

- *consumers* regarding when, where and from whom to seek health care
- *clinicians* regarding the length of visits, how to treat, and whether to refer
- *private insurers* regarding investments in cost-effective disease management
- *governments* regarding resource allocation between components of the system

The method by which healthcare providers are funded is an important influence on their behaviour.

In Australia, most health services are funded on the basis of an individual activity. For example, public hospitals in Australia are funded on the basis of global budgets and case-mix activity funding. General practice and some other primary health care services are funded on a less sophisticated activity-based model. For example, Medicare funding for general practitioners is primarily determined by the reported length of a consultation.

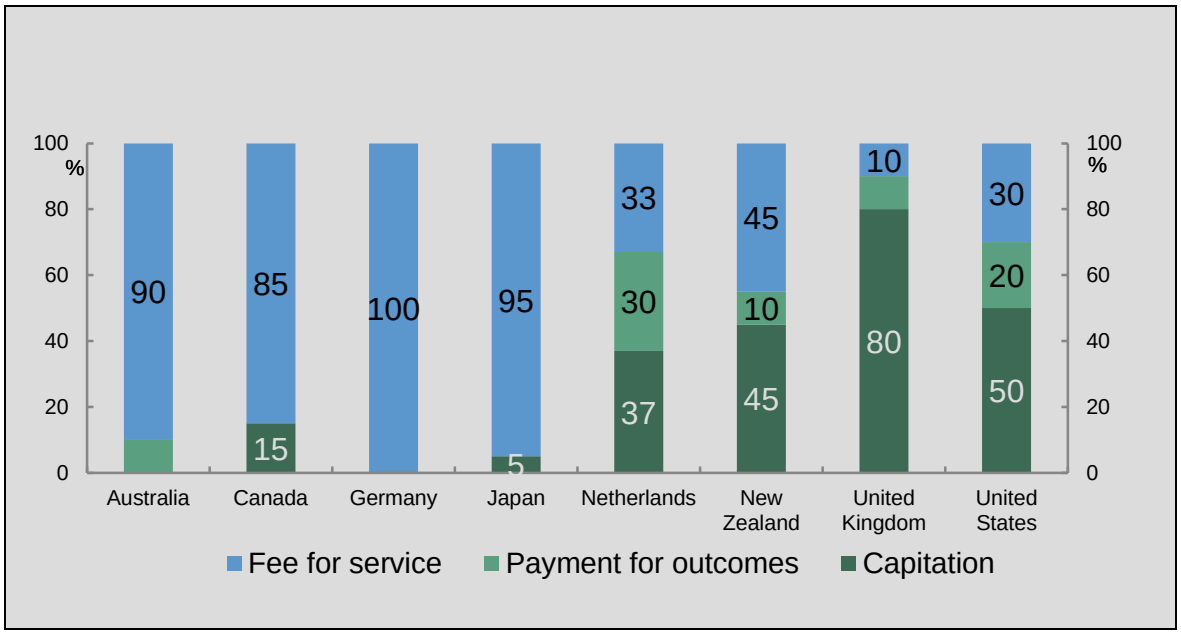
Australia's funding model is built almost entirely on fee-for-service

There is significant difference internationally on funding models for general practice and primary care. The most common primary care funding models involve one or a mix of:

- *Fee for service*: consists of reimbursement for each unit of service provided.
- *Payment for outcomes*: consists of payments for performance on pre-determined measures.
- *Capitation*: consists of periodic lump-sum payments for each enrolled patient.

Figure 18 shows that the composition of primary care funding delivered by governments in the eight comparator countries differs significantly.

Figure 18: Composition of primary care funding, by country



Source: McKinsey & Company, *How can Australia improve its primary health care system to better deal with chronic disease?*, Background paper prepared for the Primary Health Care Advisory Group, 2015

Australia's funding model is similar to Japan and Germany and primarily fee-for-service. Other countries have a much more mixed model, with the United Kingdom having the strongest focus on capitation.

All of these funding models have advantages and disadvantages. Some commentators argue that Medicare's fee-for-service focus incentivises volume of care to the detriment of patient outcomes.

While there may not be quantifiable evidence to confirm that the incentives in the funding model are a contributor to our unsustainable growth rates in health expenditure, there is vast quantifiable evidence to demonstrate the system incentives drive behaviours.

A new approach is needed

While it is appropriate for wealthy countries such as Australia to spend its growth in real income on health care, the **growth rate** of health expenditure is not sustainable.

Australia cannot afford to continue along our current trajectory. Government, household and private health insurance budgets will not be able to continue to grow to meet service demand with the system configured as it is currently.

As a wealthy nation, Australia can and should maintain high standards of health care. We should also fund new and exciting technologies and products to continue to improve our health outcomes, particularly for the groups that have poorer health outcomes than the national ones.

With no additional or new sources of revenue, we must consider other options.

PART 3: A RETHINK AND REDESIGN ARE ESSENTIAL

The task of reform

Reforming our health system is not a new concept. Governments at all levels have talked about 'fixing' hospitals and 'fixing' our health system. This has often resulted in stop-start reform agendas, and policy reversals.

The first step in redesign is to acknowledge that the health system will never be 'fixed', but it can be dramatically improved and the same outcomes delivered at a lower cost. Health reform needs to be a process of continuous improvement, and the continuous improvement needs to start with the right premise.

Australia's comparatively good health outcomes and system effectiveness means we are starting from a good base. But we do have a system that needs a substantial design overhaul and to be more future-oriented.

We need to think about what system we have now, and the system we want to move to. The task includes disrupting the incentives and economics that drive waste and inefficiency.

We need to move from a system that has an unsustainable rate of growth, to a system that will continue to offer high-quality care that is affordable for governments and individuals.

We need to move from a system where technology is not harnessed to improve outcomes and consumers are not equipped to make informed decisions or self-manage.

The emerging megatrends will drive some of these changes, particularly around consumers, but we must also deliberately rethink and redesign our health expenditure programs.

Table 1 summarises current aspects of the health system and how these are likely to evolve, based on both the trends impacting the sector and continuous improvement.

Table 1: Characteristics of the current and future health system

Current	Future
Provider-driven Healthcare providers are at the centre of the system, driven in large part by information asymmetries and fee-for-service which can be detrimental to consumer outcomes.	*Consumer-driven* Consumers are at the centre of the health system, utilising technology and information in collaboration with providers to undertake shared decision-making with providers and more proactively drive their treatment and experience of the health system.
Limited information accessibility Limited accessibility and transparency of information in the health system means that consumers and providers often do not have the right information to ensure the best course of treatment is pursued.	*Data-driven* Patient and system data is accessible and utilised to target care, with real-time analytics deployed to ensure the best use of labour and resources and effective patient outcomes.

Current	Future
Demarcated Limited incentives and accessibility of information work against continuous care and collaboration across different healthcare providers and complementary sectors.	*Collaborative* There is increased collaboration, connectivity and integration within different parts of the health sector and across complementary sectors such as aged care, information technology and recreation.
Responsive While Australia has had some success in preventative health, the current health system is particularly focused on responding to chronic health conditions at the end of life, rather than the beginning of life through prevention and healthy lifestyles from a young age.	*Preventative* There is a focus on preventing chronic disease from the beginning of life with consumers using increased information and technologies to monitor health and achieve healthier lifestyles.
Unsustainable expenditure Health expenditure is currently growing faster than the economy and placing government fiscal positions under considerable pressure. There is also evidence, as outlined in this paper, of waste across the health system, with a significant number of medical treatments applied that are unnecessary, inappropriate or deliver marginal benefit.	*Efficient Expenditure* Increased focus on consumer outcomes, lifetime preventative health, less facilities-based care and reduced waste decrease the rate of growth in expenditure.

Priority issues

In line with the earlier analysis of the system's current performance and the focus on continuous improvement, the priority issues to address in driving continuous improvement are:

1. Getting the incentives right
2. Putting the consumer at the centre of the health system
3. Reducing waste and inefficiency
4. Accessibility and transparency of information, and
5. Coordination of chronic care

Getting the incentives right

The challenge facing the Australian health system is to start the design of the funding model with the desired outcomes, and to then shape the incentives around those outcomes.

Issues for consideration

- The most significant incentives and disincentives confronting consumers, providers, private health insurance funds and governments in the health system and the greatest impediments to reshaping these incentives.

- The extent to which Australia's funding model incentivises behaviour that contributes to waste, inefficiency and poorer health outcomes.
- The existing gaps in accessibility and transparency of information that could enhance incentives for consumers, providers, private health insurance funds and governments.
- The areas in which technology and consumer empowerment are most likely to break down or disrupt traditional incentive structures in the future.

Putting the consumer at the centre of the health system

Consumers are already taking steps to manage their own health and better navigate the health system. Future reforms must both harness the opportunities and mitigate risks presented by increased consumer empowerment.

Issues for consideration

- Identifying and managing risks of increased consumer empowerment to ensure it does not work against continuous improvement – for example, through increased demand for inappropriate services based on online advice.
- The extent to which existing elements of the health system (e.g. Medicare) can redefine the role of the consumer and promote healthier lifestyles and value-focused consumption.
- The extent to which emerging trends, such as precision medicine, can redefine the role of the consumer and promote healthier lifestyles and value-focused consumption.
- Steps that will need to be taken to build on investments in electronic health records and enhance consumer engagement in, and utilisation of, their health records.

Reducing waste and inefficiency

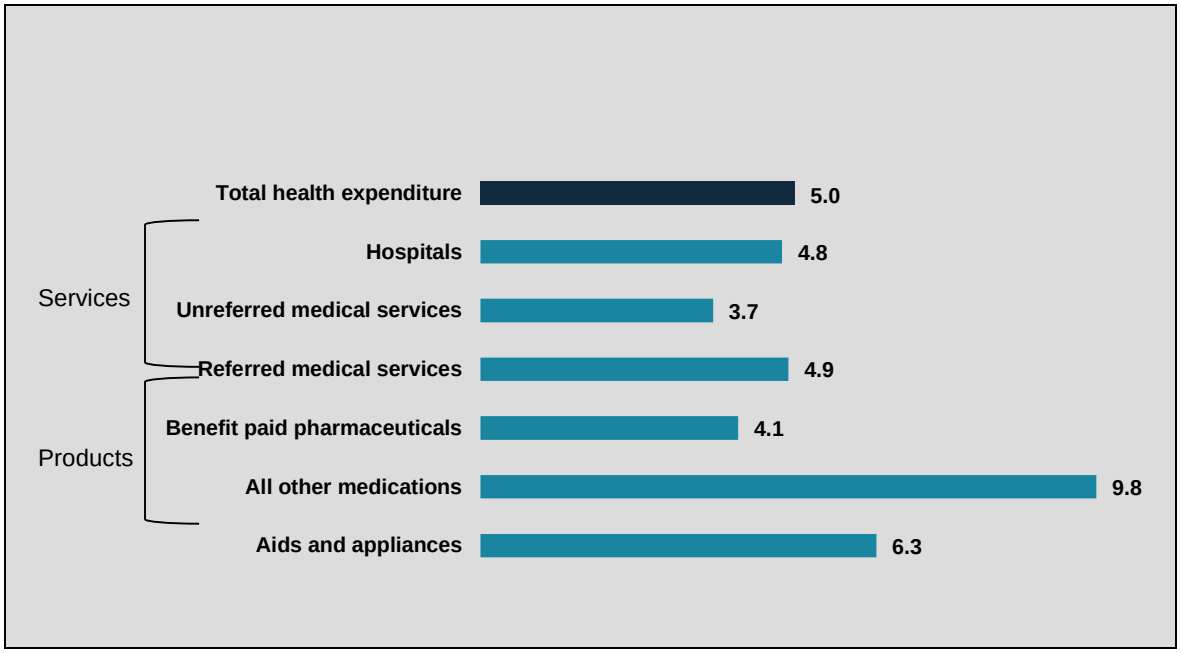
Australia can and should maintain high standards of health care. If it is to do this in a sustainable fiscal manner, it is inevitable that waste and inefficiency will need to be reduced. –

Issues for consideration

- The extent to which governments can use current fiscal pressures as a catalyst for improvement, driving quality while reducing costs.
- The contribution that technology and increased consumer empowerment can make to increasing efficiency.
- Managing potential risks to efficiency from new technology − for example, there will be a need to balance the benefits of predictive analytics with the potential costs.
- Focusing government and provider efforts in the areas of the health system most likely to generate the biggest improvements in efficiency. The top three cost areas in health care are hospitals ($59 billion), primary care ($55 billion) and secondary care

($16 billion). All components of the health system have been growing faster than GDP, but hospitals have the largest base, and therefore are a key area to consider.

Figure 19: Average annual expenditure growth, 2003–04 to 2013–14 (%)



Source: Australian Institute of Health and Welfare, Health Expenditure 2013–14

Accessibility and transparency of information

Improved incentives, increased consumer empowerment and reduced waste and inefficiency will all be underpinned by increased accessibility and transparency of information.

Issues for consideration

- Overcoming impediments to the accessibility and transparency of information already captured within the health system.
- Addressing data ownership, access and privacy concerns, including the balancing of public and private interests in how data is shared and used.
- Ensuring that collection of new information provides a clear benefit and does not involve excessive administrative burden.

Coordination of chronic care

People with chronic conditions require care from a range of primary health services, yet often experience a fragmented system. Coordination can improve care and reduce waste.

Issues for consideration

- Harnessing digital technologies to better enable self-management and remote monitoring.

- Piloting and implementing funding models that encourage continuity of care and clinical interventions at the right time to prevent avoidable hospitalisations.

Conclusion

Putting Australia's health system on a path of continuous improvement will require disruption of current institutions. If this disruption is not initiated now through a conscious effort to reform, it will be initiated by consumers or by the need for a dramatic fiscal readjustment in future.

This requires an open and honest dialogue between government, clinicians, health insurers, and the community about how we redesign incentive structures to be fit for the future, where waste can be targeted and what constitutes low value care.

It will also require a mature conversation about what services should remain part of a health safety net, and what should be options that individuals choose to fund for themselves.

If all parties come to this challenge with optimism and collaboration, we can develop a pathway to change to ensure Australia's health system can continue to deliver excellent nationwide outcomes, improve the outcomes for disadvantaged groups, and be future-facing and sustainable for the whole community.

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